November 30, 2013

Comments on the Connecticut Healthcare Innovation Plan

To Whom it May Concern:

The Community Health Center Association of Connecticut (CHCACT) appreciates the opportunity to comment on the Connecticut Healthcare Innovation Plan ("the Plan") as part of the State Innovations Model (SIM) initiative on behalf of the thirteen Federally Qualified Health Centers (FQHCs) that are its members.

CHCACT is a nonprofit organization that exists to advance the common interest of Connecticut's federally-qualified health centers (FQHCs) in providing quality health care. CHCACT is recognized as the organization most qualified by its leadership, expertise and experience in addressing the issues of significance to all FQHCs and populations needing comprehensive health care. In Connecticut, fourteen FQHC organizations provide medical, dental and behavioral health care to 340,000 residents each year, 23% of whom are uninsured.

CHCACT supports the goals of the Plan as stated:
- Better health and the elimination of health disparities for all of our residents
- Better healthcare by achieving superior quality of care and consumer experience
- A lower rate of growth in healthcare costs to improve affordability

Indeed, in these goals, the Plan describes the exact goals and outcomes of FQHCs across the state and country, which, for over forty years, have been providing unequalled access to comprehensive health care and social services to all people, regardless of ability to pay.

In addition to support for several overall themes and specific initiatives outlined in the Plan, CHCACT has suggestions for the Committee's consideration when finalizing the Plan and implementing the initiatives. These comments are organized by section of the Plan with final concluding comments as well.

Primary Care Practice Transformation/Advanced Medical Home Model

Whole-person centered care: Eleven of the state's 14 FQHCs are already recognized by either NCQA or the Joint Commission as patient-centered medical homes, with the remaining three on track to achieve recognition/accreditation in 2014. All FQHCs operate under the principles of the Advanced Medical Home – most importantly and centrally, "whole person-centered care." However, the FQHCs have received conflicting information about whether FQHCs will be eligible for the care coordination and value-based payments (SSP and P4P) which are described as "key enablers" of transformation in the Plan. The recent presentation to the FQHCs indicated that CT Medicaid has not agreed to include the FQHCs in any of the incentives for AMH. The following day, in a meeting with DSS Commissioner Bremby, the Department indicated that it had not taken such a position. In light of the decision to exclude FQHCs specifically from the current PCMH payment system in Medicaid, policy regarding inclusion of the FQHCs in AMH is of critical importance. The decision made in December, 2012 to remove FQHCs from the PCMH model has "saved" Connecticut $10 million by eliminating payments to FQHCs. The

elimination of those payments – which were expected and needed – has resulted in staff layoffs and other cutbacks, impeding access to care and services for some of Connecticut's neediest residents. Any similar developments regarding AMH would be devastating to efforts to accomplish the goals of the Plan, especially since FQHCs provide an enormous portion of the primary care for the high risk, high cost populations the Plan intends to target. It is important to note that while a larger percentage of FQHC patients are Medicaid enrollees, the FQHCs also contract with private payers and would like to be included in incentive payments in the same manner as private providers.

CHCACT requests that the final plan **explicitly include FQHCs in all aspects of AMH**, including any "upfront" assistance, shared savings and other payment system(s) tied to that model.

Enhanced Access: FQHCs are currently open the extended hours on evenings and weekends that are contemplated in the Plan. In addition, the providers and support staff at FQHCs are well schooled in cultural competency and many speak the languages of the patients they serve. However, access to specialty services in a key barrier for FQHC patients. Efforts to enhance health care access for underserved, high minority populations are challenging; specifically, FQHCs have had difficulty with referrals to specialty care of all kinds for diagnosis and treatments of conditions that require specialists – cardiology, radiology, dermatology, orthopedics, etc. The encouragement of eConsults to address the many barriers to specialty care is enthusiastically supported. CHCACT offers to work with the Committee to improve access to all of Connecticut's residents.

Provider Aggregation to Achieve Scale and Capabilities

This section is not applicable to FQHCs, which are deeply rooted in their communities and governed by community-based boards. FQHCs already share Best Practices through CHCACT's quality initiatives as well as collaborations with eHealth CT and Qualidigm. CHCACT was funded by the Health Resources and Services Administration (HRSA) in 2012 to establish a Health Center Controlled Network (HCCN). The three requirements for that funding include CHCACT and its member FQHCs: a) improve population health through the use of Health Information Technology (HIT); b) reduce health disparities; and c) improve operational and clinical quality. To achieve these goals, the FQHCs have already completed full adoption of EHR at all sites. In collaboration with eHealth CT, the HCCN continues to promote and support network-wide Meaningful Use practices and develop and implement network-wide, population-based quality improvement strategies using popHealth. In addition, the HCCN will soon have a centralized health information database for quality improvement. These innovations position the FQHCs to be full participants in the quality improvement initiatives and incentives included in the Plan.

Community Health Improvement

CHCACT supports all efforts towards community health improvement and suggests that an inventory of community- and statewide initiatives be undertaken as a first step, to ensure coordination, maximization of funds and lack of duplication of efforts.

Additionally, CHCACT supports the inclusion of FQHCs in the envisioned Diabetes Prevention Program. CHCACT respectfully suggests that assistance with design and implementation of that program could build upon the FQHCs' successful collaboration with the CT DPH Diabetes Prevention program as part of the ten-year long HRSA-funded national Health Disparities Collaborative.

Consumer Empowerment

As FQHCs are governed by consumer-majority boards, CHCACT has seen the impact that consumer empowerment can have – not just for those specific consumers, but for an entire community. As such, CHCACT supports efforts towards consumer empowerment. CHCACT currently provides training and technical assistance to FQHC Boards of Directors to assure they comply with the governance requirements for FQHCs[1]. CHCACT and the FQHCs are well positioned to gather input from consumers and recruit consumers to participate in a Consumer Advisory Board.

Performance Transparency

FQHCs operate in a transparent system, through the use and publication of the Uniform Data System (UDS). Each year, FQHCs report patient demographic data, financial data and clinical outcome measures on diabetes, hypertension, childhood immunization rates, prenatal care, tobacco use and other quality measures. These data are analyzed, benchmarked statewide and nationally so that FQHCs can utilize this information for management and quality improvement. CHCACT supports all efforts towards performance transparency for ALL health care providers.

Ensuring Equity and Access

The Plan acknowledges that providers might attempt to improve their quality metrics through adverse risk selection. CHCACT notes that FQHCs are required by federal law to treat all patients who seek their services. Because FQHCs are prohibited from turning patients away, the FQHC patient population differs greatly from the state's population as a whole. For example:

	Connecticut Residents	CT Health Center Patients (UDS, 2012)
White, non-Hispanic	70.3%	27%
African-American/Black	11.2%	25%
Hispanic/Latino	14.2%	45.4%
Receiving Medicaid	13%	60%
Uninsured	10%	23%
Below 200% of Poverty Level	21%	94%

[1] HRSA's FQHC program requirements mandate that the health center governing board is composed of individuals, a majority of whom are being served by the center and, this majority as a group, represent the individuals being served by the center in terms of demographic factors such as race, ethnicity, and sex. And that non-consumer members of the board shall be representative of the community in which the center's service area is located and shall be selected for their expertise in community affairs, local government, finance and banking, legal affairs, trade unions, and other commercial and industrial concerns, or social service agencies within the community with no more than one half (50%) of the non-consumer board members deriving more than 10% of their annual income from the health care industry.

CHCACT offers to work with the Committee to improve access to all of Connecticut's residents. Further, CHCACT supports the concept of a Certified Community-Based Practice Support Entity to promote population health and build on the best practices already shared amongst FQHCs through CHCACT.

Healthcare Workforce Development

FQHCs across the state report difficulty with recruiting and retaining providers and consistently rate this as a high priority for both the short-term and long-term.

Connecticut Service Track: The Connecticut Service Track program would assist Connecticut's three rural FQHCs (Community Health & Wellness Center of Greater Torrington, Generations Family Health Center and United Community & Family Services) in meeting some of these recruitment challenges. The FQHCs and CHCACT have been active in the development and growth of the Urban Service Track initiatives and would be pleased to participate in the extension and expansion of that successful program.

Training and Certification Standards for Community Health Workers: FQHCs utilize community health workers (CHWs) for a variety of consumer-oriented, nonmedical tasks, including patient navigation, outreach and enrollment, scheduling, health education and more. As such, CHCACT has actively participated in conversations around the credentialing of CHWs. Although the CHW movement is grassroots, opportunities for standardized training would enhance the FQHC workforce and the services provided to consumers to improve their quality of life and potentially save the system money by diverting care from emergency departments. The Plan does not explicitly state whether the state will encourage payers to reimburse for the services provided by CHWs; **CHCACT requests that payment for CHW services including those at FQHCs be specifically recommended in the finalized report.**

Developing Innovative Post Graduate Clinical Education and Residency Programs in Primary Care

Changes to the state's post-graduate clinical education could have a huge impact on the ability of FQHCs to recruit providers. Currently, a few FQHCs work with hospitals to utilize residents; however, the majority of them do not have arrangements to do so, despite best efforts to achieve this partnership. Overall, FQHCs would be interested in pursuing partnerships with medical schools, allied health training programs, nursing schools and more to expose students and post-graduates to the unique work of FQHCs and the challenges and opportunities available.

The inclusion of funding to match the federal funds available for loan repayment and/or forgiveness programs are essential to the workforce development necessary to the Plan's success. The National Health Services Corps (NHSC) loan program offers primary care medical, dental, and mental and behavioral health providers the opportunity to have their student loans repaid while serving in communities with limited access to care. FQHCs must be located in these Health Professional Shortage Areas (HPSAs) in order to qualify for their federal grant funding. Primary care providers working full-time at sites approved for National Health Service Corps (NHSC) loan repayment that have a HPSA score of 14 or above can receive up to $60,000 in loan repayment for committing to serve at site for at least two years. Primary care providers

working full-time at an NHSC-approved site with a HPSA score of 13 or below can receive up to $40,000 in loan repayment for committing to serve at the site for at least two years.
State-run loan repayment programs offer another loan repayment option to primary care providers. Like the NHSC Loan Repayment Program (LRP), these state programs offer educational loan repayment programs for providers working in Health Professional Shortage Areas (HPSAs). Both loan repayment programs work together to improve access to health care in communities with a shortage of health professionals. CHCACT is able to provide historical data on the efficacy of state loan repayment as a recruitment and retention strategy. These programs historically have provided needed assistance to new providers, while also creating a pipeline for FQHC recruitment.

Other Comments

Scope of Practice Issues

CHCACT would support investigation and analysis of scope of practice issues to allow individuals to practice at the top of their licenses and capabilities. FQHCs depend heavily on the skills and availability of mid-level providers, particularly APRNs, Physicians' Assistants, and other allied health professionals to meet productivity metrics. The importance of scope of practice is not explicitly mentioned in the Plan, but consideration of ways to maximize licensed independent professionals (LIPs) would improve access to health care services and the efficiency of practices across the spectrum.

Alignment of Performance Metrics

CHCACT asks for the consideration of other initiatives (e.g., Complex Care/Health Neighborhoods) in developing performance metrics. Aligning metrics across initiatives would lessen the administrative burden on providers; it may be appropriate to have a core set of metrics, with 2-3 measures that differ across initiatives.

Additionally, CHCACT asks the Committee to consider the inclusion of pain management as a performance metric. FQHCs are required to provide substance abuse treatment within their scope of service and have successfully used pain management contracts to reduce substance abuse for their patients but have encountered many barriers to coordinating pain management efforts with other providers, specifically emergency departments. The experience of the FQHCs has been that the use of opiates across provider settings is widely unmanaged, costly and – of course – not beneficial to patients' overall quality of life.

Legislative/Regulatory Changes

CHCACT will provide additional details on requested legislative and regulatory changes over the next several weeks. For example, recently adopted regulations have presented obstacles to behavioral health service delivery by requiring far too many staff resources for physician "sign-offs" of care provided by mid-level providers.

Integration of Primary Care, Behavioral and Oral Health

Although the Plan references integration, CHCACT requests that more specific detail be added that clarify that behavioral health and oral health are included in the AMH model, and its associated performance measures and payment systems. While behavioral health has begun to receive attention from health care providers and policymakers (unfortunately due to several

tragedies), oral health is often unmentioned and not prioritized. FQHCs have recently embarked on a best practices project to embrace the integration of primary medical and behavioral health services which has been shown to improve outcomes while reducing overall costs. The vast majority of patients in primary care have a physical ailment that is affected by stress, problems maintaining healthy lifestyles, and/or a behavioral health disorder; at the same time, people with serious mental health and substance abuse problems have higher rates of chronic illnesses. Therefore, to successfully respond to co-occurring disorders, as demonstrated by research over the past several decades, it is clinically beneficial, as well as cost effective, to deliver integrated and well-coordinated services.

Rural Access

CHCACT requests that the Committee **explicitly state its goals towards access to care for residents of rural parts of the state.** Although other health disparities are mentioned, geography is not given its due consideration. In certain parts of Connecticut (e.g., the Northeast corner), there are no specialists within an hour's range, which would impede access for almost anyone regardless of their insurance coverage. This access is further hampered for low-income residents, who often have transportation issues in addition to difficulty accessing diagnostic and treatment resources linked to specialty care.

Consumer Protections

CHCACT requests the Committee add the following consumer protections to the final Plan:

- Providers found to have denied or restricted access to necessary care will be prohibited from receiving shared savings or other financial rewards
- Robust quality measures for surveillance to avoid "under-treatment" must be developed in an inclusive committee with significant independent consumer advocacy membership
- The system to measure and sanction under-treatment, and a fair process to resolve disputes, will be in place **before** any provider incentives are implemented
- All decisions will be reached in a transparent, public process based on significant public input
- Independent consumer advocates will be included in meaningful numbers on all SIM committees
- As in the first SIM plan draft, downside risk payment models are excluded in the Medicaid program

Thank you for this opportunity to comment on this Plan. CHCACT will have more detailed comments throughout the process and looks forward to a continued partnership in improving the health of Connecticut residents.